

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 6/29/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental retardation. The census at the time of the survey was nine. Nine resident files were reviewed and four employee files were reviewed. The facility received a grade of D.</p> <p>Complaint #NV00022386 was substantiated. See Tag Y878</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 105 SS=E	<p>449.200(1)(f) Personnel File - Background Check</p> <p>NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.</p> <p>This Regulation is not met as evidenced by: Based on record review on 6/29/09, the facility</p>	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 105	Continued From page 1 failed to ensure 1 of 4 caregivers met background check requirements (Employee #3 was missing finger prints, state and FBI background checks and an initial physical). Severity: 2 Scope: 2	Y 105			
Y 106 SS=F	449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Based on interview and record review on 6/29/09, the facility failed to ensure that 1 of 4 employees (Employee #3) completed training in first aid and cardiopulmonary resuscitation (CPR), affecting all #9 residents. Severity: 2 Scope: 3	Y 106			
Y 273 SS=F	449.2175(4) Service of Food - Special Diets NAC 449.2175 4. A resident who has been placed on a special diet by a physician or dietitian must be provided a meal that complies with the diet. The administrator of the facility shall ensure that	Y 273			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 273	Continued From page 2 records of any modification to the menu to accommodate for special diets prescribed by a physician or dietitian are kept on file for at least 90 days. This Regulation is not met as evidenced by: Based on observation and interview on 6/29/09, the facility failed to provide a low sodium diet to 2 of 2 residents on a special diet (Resident #8 and #9). Severity: 2 Scope: 3	Y 273		
Y 274 SS=C	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal. This Regulation is not met as evidenced by: Based on observation and interview on 6/29/09, the facility failed to ensure menu substitutions were documented and retained for at least 90 days. Severity: 1 Scope: 3	Y 274		
Y 530 SS=C	449.260(1)(e) Activities for Residents	Y 530		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 530	Continued From page 3 NAC 449.260 (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. This Regulation is not met as evidenced by: Based on interview and observation on 6/29/09, the facility failed to ensure 10 hours of activities each week that were suited the the residents interests and capacities. Severity: 1 Scope: 3	Y 530			
Y 557 SS=D	449.262(3)(a) Restriction on Use of Restraints NAC 449.262 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident. This Regulation is not met as evidenced by: Based on observation on 6/29/09, the facility failed to ensure full bed rails were not being used on 3 of 10 beds. Severity: 2 Scope: 1	Y 557			
Y 876 SS=B	449.2742(4) NRS 449.037 NAC 449.2742 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of	Y 876			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 876	Continued From page 4 controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.037 are met. This Regulation is not met as evidenced by: Based on record review on 6/29/09, the facility failed to ensure that an ultimate user agreement was obtained for 4 of 9 residents (Resident #1, #3, #7, and #8). Severity: 1 Scope: 2	Y 876			
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review on 6/29/09, the facility failed to ensure that 1 of 9 residents received medications as prescribed (Resident #3). Bactroban 2% cream was prescribed to be applied to the affected area 3 times a day. The MAR was only signed for 6/15/09 in the am, 6/17/09 in the am, 6/18/09 in the am, 6/22/09 in	Y 878			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 5 the am and 6/23/09 in the am. Senna plus there was a discrepancy between the doctors orders, what was on the bottle and what was written on the MAR. The facility failed to administer PRN medications to 1 of 9 residents (Resident #3) as prescribed. PRN medications were given routinely. Severity: 2 Scope: 1	Y 878		
Y 885 SS=D	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Based on observation on 6/29/09, the facility failed to ensure medications for 1 of 9 residents were destroyed (Resident #3). Ultram and Bentyl were both discontinued by the doctor, and the bottles were still in the residents box. Temazepam and Haldol prescription strength were changed and the old prescriptions were still in the resident's medication box.	Y 885		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 885	Continued From page 6 Severity: 2 Scope: 1	Y 885		
Y 920 SS=F	<p>449.2748(1) Medication Storage</p> <p>NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.</p> <p>This Regulation is not met as evidenced by: Based on observation on 6/29/09, the facility failed to ensure that medications belonging to 9 of 9 residents were secured (Resident #1, #2, #3, #4, #5, #6, #7, #8 and #9).</p> <p>Severity: 2 Scope: 3</p>	Y 920		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 930	Continued From page 7	Y 930		
Y 930 SS=C	<p>449.2749(1)(a) Resident File</p> <p>NAC 449.2749</p> <p>1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation:</p> <p>(a) The full name, address, date of birth and social security number of the resident.</p> <p>This Regulation is not met as evidenced by: Based on observation on 06/29/09, the facility failed to ensure 9 of 9 (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) resident files were kept in a locked place.</p> <p>Severity: 1 Scope: 3</p>	Y 930		
Y 936 SS=F	<p>449.2749(1)(e) Resident file</p> <p>NAC 449.2749</p> <p>1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation:</p> <p>(e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations</p>	Y 936		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS297AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2009
NAME OF PROVIDER OR SUPPLIER PARADISE CREST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4462 FARMCREST DRIVE LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	Continued From page 8 adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 6/29/09, the facility failed to ensure 2 of 9 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #2, and #7) which affected all residents. Severity: 2 Scope: 3	Y 936			
Y 953 SS=D	449.275(3)(a)(b) Hospice Care NAC 449.275 3. If the Division grants a request made pursuant to NAC 449.2736 by the administrator of a residential facility that provides hospice care, the residential facility may retain a resident who: (a) Is bedfast, as defined in NAC 449.2702. (b) Requires skilled nursing or other medical care on a 24 hour basis. This Regulation is not met as evidenced by: Based on interview and observation on 6/29/09, the facility failed to apply for a waiver to retain 1 of 9 residents who is on hospice and is bedfast. Severity: 2 Scope 1	Y 953			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.